Appendix 10
Prior Authorization Therapy Attachment (PA/TA) Sample
(Physical Therapy)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT
(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	Im	A	1234567890	69

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. Performing	12345600	(XXX) XXX - XXXX

⑨ I.M. Referring/Prescribing
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 15 minutes
Total Sessions per week requested: 3
Total number of weeks requested: 11

C. Provide a description of the recipient's diagnosis and problems including date of onset.

R CVA

Hysterectomy 2° adenocarcinoma - 1992
Adult onset diabetes - several years duration
CHF - several years duration

D. Brief Pertinent History:

Patient was admitted 3/12/95 after hospitalization for acute CVA 2/27/95.

Hospitalized from 5/6/95 to 5/12/95 for pneumonia. Has been medically stable and alert since return on 5/12/95.

E. Therapy History:

	Location	Date	Problem Treated
PT	Hospital	3/1/95 to 3/11/95	CVA
	Nursing Home	3/13/95 to 5/6/95	CVA
		5/13/95 to present	

OT

N/A

SP

N/A

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)

	3/12/95	5/12/95
Orientation	A & O x 3	A & O x 3
ROM	WFL except L shldr flex= 0-140° Abd.= 0-140° Lat. Rot.= 0-45° L knee ext. = 10-100°	WFL except L shldr flex= 0-110° Abd.= 0-110° Lat. Rot.= 0-45° L knee ext.= 15°-95° L ankle dorsi flex= -10°
Strength	R extremities in GOOD range L UE flaccid L LE hip & knee POOR range	R U & L E F+ to GOOD- L UE non-func C moderate Flexor spasticity present L LE hip & knee FAIR L ankle TRACE
Transfers	Stnding pivot requires max of 2	Standing pivot mod of 1
Elevations	Supine ↔ sit max of 1 Sit ↔ stand max of 2	Supine ↔ sit min of 1 Sit ↔ stand mod of 1
Ambulation	Non-ambulation	In parallel bars of 10'x2 with max assist of 1, able to advance L LE indep. 70% of time
Sitting Balance	Unsupported requires max of 1	Unsupported indep. x 60 sec if unchallenged

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

6/18/92

Orientation	0
ROM	L knee ROM= 5-100° L ankle dorsi flex= 0°
Strength	R UE & RLE - GOOD →G+ L UE-Zero, L LE - hip & knee - FAIR- ankle-POOR range, AFO obtained 5/15/95 to assist in transfer/gait.
Transfers	Standing pivot with guarded to min of 1 in PT & on unit
Elevations	Supine ↔ sit ↔ stand with guarded to min of 1.
Ambulation	10'x2 with minimum of 1 and hemi-walker. Amb. 1 x1/day on nursing unit.
Sitting Balance	Able to accept moderate challenges and maintain sitting balance.

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

	GOALS	PROCEDURES
1.	Amb. with cane With SBA of 1, 120'x2	Gait training Therapeutic exercise
2.	Indep. mobility, transfers	Therapeutic exercise
3.	Left knee ROM - Normal	Therapeutic exercise
4.	Left ankle strength POOR^{+} →FAIR	

Long Term Goals - Independent mobility, LLE ROM WNL, Return to semi-independent living

★ Code 97032 requested as possible adjunct, to therapeutic exercise.

I. Rehabilitation Potential:

Very good potential to meet goals. Patient has progressed steadily with short period of decline in May only.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J.

Signature of Prescribing Physician (A copy of the Physician's order sheet is acceptable)	Signature of Therapist Providing Treatment
MM/DD/YY Date	MM/DD/YY Date